APPLICATION INFORMATION

PRINT or TYPE all information on the forms.

This is an application packet for Respiratory Care Practitioners. **An incomplete application will not be processed until all required fees and documents are received.**

Please allow 4 to 5 weeks for processing from the day you mail in your application. (even if you mail it overnight)!

After an application is received it is entered into the computer system and screened for completeness in the order in which it is received. Staff which perform the screening also process renewals, continuing education, and all fees received by the RCP program. Please be patient.

After an application is screened it will be approved, disapproved or a deficiency may be noted. Applications which are complete will be approved and a certificate will be sent to the applicant. Those which are disapproved or are incomplete will be sent notices listing the deficiencies or reasons for disapproval.

Each form is labeled at the bottom. All applicants MUST complete Form A, Declaration Form and the entire General Application, Form B. Do NOT leave any questions or sections blank on Form B. Put N/A if a particular item is "not applicable". ALL applicants MUST have page 4 of Form B NOTARIZED by a Notary Public. NO EXCEPTIONS. The forms must be postmarked within 30 days after signing.

All applicants MUST include a RECENT color photograph (minimum 1 1/2" x 1 1/2"). PRINT your name on the back.

NON-REFUNDABLE FEES - NO EXCEPTIONS

REGULAR CERTIFICATE applicants MUST include the $60.00 non-refundable application fee.

TEMPORARY PERMIT applicants MUST include the $50.00 non-refundable application fee.

In accordance with Texas Civil Statutes, Article 4512l, you cannot practice respiratory care until this application is processed and certificate or temporary permit is issued. To do so, could detrimentally effect the approval of the application and is grounds for disapproval of the application. If you have any questions after reading the Act and the Rules, please contact my office at 512/834-6632.

TO EXPEDITE APPLICATION PROCESSING DETACH THE PAYMENT COUPON AND SUBMIT ALONG WITH THE APPLICATION, FEE AND SUPPORTING DOCUMENTATION TO THE ADDRESS ON THE COUPON.

CUT ALONG THIS LINE

PAYMENT COUPON **BUDGET # ZZ013**
FUND # 127

NAME _____

SOCIAL SECURITY NUMBER _____ YOU MUST RETURN THIS COUPON WITH YOUR APPLICATION

AMOUNT ENCLOSED _____

TDH/RESPIRATORY CARE PRACTITIONERS
P. O. BOX 12197
CAPITOL STATION
AUSTIN, TEXAS 78711-2197

BUDGET ZZ013
FUND 127

TEXAS DEPARTMENT OF HEALTH
RESPIRATORY CARE PRACTITIONERS CERTIFICATION PROGRAM
1100 WEST 49TH STREET
AUSTIN, TEXAS 78756-3183
(512)834-6632

DECLARATION FORM

READ The Respiratory Care Practitioners Act and TDH Rules before filling out this application. Please allow 4 to 5 weeks for processing. Carefully follow the instructions provided.

TYPE OR PRINT LEGIBLY

I. Name _____
(last) (first) (middle)

Social Security Number _____ - _____ - _____

Check method of Application (Do not check more than one).

A._____ **Regular Certificate - Certified Respiratory Therapy Technician (CRTT).** Refer to §123.7(d)(2) of the rules.

1. Submit a non-refundable $60.00 application fee.
2. Submit a photocopy of your CRTT certificate issued by the National Board for Respiratory Care or its predecessor organization (DO NOT SUBMIT Active Status Card).
3. If CRTT credential was earned after September 1, 1985, the following also needs to be submitted:
   (a) a notarized copy of a high school diploma or high school equivalency; or an associate, baccalaureate, or post-baccalaureate degree from an accredited college or university.
   (b) an official transcript or notarized copy of a certificate of completion or degree which clearly indicates completion of a respiratory care education program OR
4. Applicants who have been awarded a bachelor's or associate degree in respiratory care (RC) may submit a notarized copy of that degree to satisfy both RC education and high school education requirement.

B. _____ **Regular Certificate - Registered Respiratory Therapist (RRT).** Refer to §123.7(d)(2) of the rules.

1. Submit a non-refundable $60.00 application fee.
2. Submit a photocopy of your RRT certificate issued by the National Board for Respiratory Care or its predecessor organization.
3. Submit your CRTT certificate or other proof with the date the CRTT credential was earned.
4. If RRT credential was earned after September 1, 1985, the following also needs to be submitted:
   (a) a notarized copy of a high school diploma or high school equivalency; or an associate, baccalaureate, or post-baccalaureate degree from an accredited college or university.
   (b) an official transcript or notarized copy of a certificate of completion or degree which clearly indicates completion of a respiratory care education program OR
5. Applicants who have been awarded a bachelor's or associate degree in respiratory care (RC) may submit a notarized copy of that degree to satisfy both RC education and high school education requirement.

C. _____ **Temporary Permit - Graduate of an accredited respiratory care education program**.
Refer to §123.7(d)(1)of the rules.

1. Submit a non-refundable $50.00 application fee.
2. Submit a notarized copy of a high school diploma or high school equivalency; or an associate, baccalaureate, or post-baccalaureate degree from an accredited college or university.
3. Submit an official transcript or notarized copy of a certificate of completion or degree which clearly indicates completion of a respiratory care education program OR
4 Applicants who have been awarded a bachelor's or associate degree in respiratory care (RC) may submit a notarized copy of that degree to satisfy both RC education and high school education requirement.

D. _____ **Temporary Permit - Student enrolled in an accredited respiratory care education program, being within 45 days of completion**. Refer to §123.7(d)(1) of the rules.

1. Submit a non-refundable $50.00 application fee.
2. Submit a notarized copy of a high school diploma or high school equivalency; or an associate, baccalaureate, or post-baccalaureate degree from an accredited college or university.
3. Submit an expected graduation statement signed by the program director.
4. Submit an official transcript or notarized copy of a certificate of completion or degree which clearly indicates completion of a respiratory care education program which must be submitted within 30 days of the completion date, refer to §123.6(c)(2)(C)(i) and (ii) of the rules.

E. _____ **Regular Certificate - OUT OF STATE LICENSE -** Refer to §123.7(d)(3).

Applicants who hold the CRTT or RRT credential.

1. Submit a non-refundable $60.00 application fee.
2. Submit documentation requested in Method A or B on Form A, Page 1.
3. Complete and submit Form C.
4. Form D must be submitted to the licensing agency in the state, territory or country which issued the license for license verification.

Approval of an application under this method cannot be processed until the Form D has been received from that state, territory or country providing the verification. (Some states require a fee, paid in advance, for providing clearance information. To expedite, you may wish to contact the applicable agencies).

F. _____ **Temporary Permit - OUT OF STATE LICENSE -** Refer to §123.7(d)(3).

Applicants who DO NOT hold the CRTT or RRT credential.

1. Submit a non-refundable $50.00 application fee.
2. Submit documentation requested in Items C or D above.
3. Complete and submit Form C.
4. Form D must be submitted to the licensing agency in the state, territory or country which issued the license for license verification.

Approval of an application under this method cannot be processed until the Form D has been received from that state, territory or country providing the verification. (Some states require a fee, paid in advance, for providing clearance information. To expedite, you may wish to contact the applicable agencies).

BUDGET ZZ013
FUND 127

TEXAS DEPARTMENT OF HEALTH
RESPIRATORY CARE PRACTITIONERS CERTIFICATION PROGRAM
1100 WEST 49TH STREET
AUSTIN, TEXAS 78756-3183
512/834-6632

GENERAL APPLICATION

1. Last Name _____ 2. First Name _____

3. Middle Name _____ 4. Maiden Name _____

4. Name(s) on documents if different from #1. _____

5. Mailing Address _____
City _____ State _____ Zip ___
Telephone Number (Include Area Code): _____

6. Birthdate Month _____ Day _____ Year _____

7. Social Security Number_____ - _____ - _____

8. Have you ever been convicted of any crime other than a minor traffic violation? YES _____ NO _____
NOTE: If yes, a copy of the charges and disposition papers MUST be attached.
Driving while intoxicated (DWI) is NOT a minor traffic violation.

9. Have you ever possessed an RCP certificate or temporary permit issued by Texas Department of Health?
YES ___ NO ____ Certificate or Temporary permit # _____ Expiration date_____

10. Have you ever possessed a license(s), registration, or certificate(s) to practice respiratory care issued by any other organization or state(s) ? YES_____ NO _____
If YES, give license, registration or certificate number(s), title(s), and the name(s) and address(es) of the organization(s) or state(s) issuing the license(s) or certificate(s) _____
_____

11. Have you ever possessed a license(s) registration, or certificate(s) to practice in any other profession?
(RN/LVN/PT/AT/EMT/ECA/OTHER: _____ Yes _____ NO _____
IF YES, give license, registration or certificate number(s), title(s), and the name(s) and address(es) of the organization(s) or state(s) issuing the license(s) or certificate(s)_____
_____
Form D has been sent to that organization or state? YES _____ NO _____ Date Sent _____

12. Have you ever been denied any license or certificate? YES _____ NO _____ If YES, briefly state the reason(s):
_____
_____

13. Have you ever had any license(s) or certificate(s) revoked, cancelled, or suspended? YES _____ NO _____
If YES, briefly state the reason(s): _____
_____

CURRENT EMPLOYMENT INFORMATION

14. Are you currently practicing Respiratory Care? Are you seeking to practice Respiratory Care?

YES _____ NO _____ YES _____ NO _____

(Check appropriate box) If "YES", YOU MUST complete Parts (a) - (g)

(a) Place of Employment:

(b) Address: _____

(c) City: State: Zip:

(d) Telephone Number (include area code): Ext.:

(e) Position Title: _____ Normal working Hours: _____
Briefly describe your job duties: _____
_____

(f) Date of Employment From (MONTH/YEAR) _____

(g) Medical Director's Printed Name _____
Texas License Number _____
Medical Director's Signature _____

******NOTE: If you are practicing under a Exception to Certification as listed in Section 9 of T.C.S., Article 4512l you MUST submit appropriate documentation.**

PRIOR WORK EXPERIENCE

15. List jobs held and type of work performed in the field of respiratory care for the 12 months **prior to your current position**. Begin with your last position (answer "none" if no other jobs have been held). Use separate sheet as needed to cover last 12 months.

Place of Employment _____
Address _____
City: _____ State: _____ Zip: _____

Date of Employment FROM (MO/YR) _____ TO (MO/YR) _____

ACADEMIC TRAINING

16. All applicants must list last high school attended, AMA-accredited respiratory care programs attended or completed and all colleges, universities and institutions attended. Attach additional pages if necessary.

A. Name of High School: _____

Location (City, State): _____

_____ Diploma _____ Certificate of High School Equivalency

Date Granted (MO/YR): _____

B.1. Name of College/University/Institution: _____

Location (City, State): _____

Inclusive dates attended: From (MO/YR):_____ To (MO/YR):_____

Type of Degree Granted (Circle One)

a) Associates
b) Baccalaureate
c) Post-Baccalaureate

Major Field _____

Certificate of Completion YES / NO Date Granted _____

B.2. Name of College/University/Institution:_____

Location (City, State): _____

Inclusive dates attended: From (MO/YR):_____ To (MO/YR): _____

Type of Degree Granted (Circle One)

a) Associate
b) Baccalaureate
c) Post-Baccalaureate

Major Field _____

Certificate of Completion YES / NO Date Granted _____

PLEASE READ CAREFULLY

APPLICANT'S CURRENT COLOR PHOTOGRAPH

17. Attach your passport size COLOR photograph here (minimum size 1 1/2" x 1 1/2"). The photograph should be of the applicant's head and shoulders ONLY. Photograph must have been taken within six months previous to date of application. PRINT YOUR NAME ON THE BACK OF YOUR PICTURE. Black and white pictures, cut-outs, newspaper clippings, sub-size pictures, photocopies, etc., WILL NOT BE ACCEPTED. This photograph will be used in connection with your application for the purpose of complaint(s)/violation(s) investigations. All applications are open to the public under the Texas Public Information Act.

AFFIDAVIT

18. **READ CAREFULLY - THIS FORM MUST BE SIGNED WHILE IN THE PRESENCE OF A NOTARY PUBLIC. THIS FORM MUST BE POSTMARKED WITHIN 30 DAYS AFTER SIGNING.**

(Applicant's printed name)

_____, being duly sworn according to law, deposes and says that herein contained are true in every respect; and that she/he has read and understands this affidavit; has read and will abide by the rules and regulations relating to the certification of respiratory care practitioners as specified in §123.1 - 123.14; understands that ALL FEES ARE NON-REFUNDABLE; that additional fees are required to be paid prior to issuance of and to renew any renewable certificate and permit; and that successful completion of an examination and payment of all fees are required to upgrade a temporary permit to a renewable certificate.

The applicant agrees to notify the department in writing within thirty (30) days of ANY CHANGE of name, address, or place of employment and agrees to return any certificate and identification card to the department upon the revocation, suspension or cancellation of that certificate/temporary permit. The applicant further acknowledges that she/he is responsible for keeping the certificate or permit current in order to perform respiratory care procedures on human beings for medical purposes. The applicant agrees to comply with the rules relating to renewal, continuing education and violations and subsequent actions.

Signature of Applicant _____

Subscribed and sworn to before me this _____ day of _____, 19 _____.

NOTARIAL SEAL (MUST INCLUDE EXPIRATION DATE)_____Notary Public Signature

_____

Typed/Printed Name of Notary

TEXAS DEPARTMENT OF HEALTH
RESPIRATORY CARE PRACTITIONER CERTIFICATION PROGRAM
1100 WEST 49TH STREET
AUSTIN, TEXAS 78756-3183
512/834-6632

EXPERIENCE DOCUMENTATION REPORT FORM

SUBMIT THIS FORM ONLY IF YOU ARE APPLYING FROM ANOTHER STATE

The following information must be signed by the medical director/licensed physician attesting that the applicant is presently functioning as a respiratory care practitioner. However, if the applicant is not currently working, use this form to document practice within the 12-month period prior to applying for Texas certification.

TYPE OR PRINT LEGIBLY

Applicant's Name: _____
(Last) (First) (Middle)

Social Security Number: - -

Preferred Mailing Address: _____
(Street or Box Number)

_____ (City)
(State) (Zip)

The physician attesting to his/her knowledge of the experience of the individual above shall complete the information below.

TYPE OR PRINT LEGIBLY.

I, _____, certify that I have been the medical director
(Physician's printed name)

of _____ from _____ to _____.
(Applicant) (Mo/Day/Yr) (Mo/Day/Yr)

and that I know of my own knowledge that the said person has practiced respiratory care under my direction during the dates indicated.

1. Place of Employment: _____

2. Address of Employment: _____

3. City, State and Zip: _____

4. Job Title: _____

5. Type of Facility: _____

6. Type of Work Performed (be specific): _____

On this _____ day of _____, 19 _____, in _____,
(City) (State)

I certify under penalty of perjury that the information submitted is true and correct.

_____ _____
Signature of Medical Director/Licensed Physician) (License Number)

RESPIRATORY CARE PRACTITIONERS CERTIFICATION PROGRAM
Texas Department of Health
1100 West 49th Street
Austin, Texas 78756-3183

Please complete top portion and forward one form to each state, territory, or country in which you hold or have ever held any professional license. Extra forms may be copied if needed.

NOTE: Some states require a fee, paid in advance, for providing clearance information. To expedite, you may wish to contact the applicable agencies.

CLEARANCE FROM OTHER STATE BOARDS

Print or type name _____ Social Security Number_____

I was granted license # _____ on _____ by the State of _____. The State of Texas requests that I submit evidence that my license in the State of _____ is in good standing. You are hereby authorized to release any information in your files, favorable, or otherwise, directly to the Texas Respiratory Care Practitioners Certification Program at the above address. Your early attention is appreciated.

_____
Signature

Please complete and return this form to the Texas Respiratory Care Practitioners Certification Program.

Type of License (respiratory care, etc.) _____
State of _____ Name of Licensee _____
License/Certification No. _____ Date Issued _____

Licensed/Certified Through (Check one)

____ NBRC Examination ____ State Board Examination

____ Reciprocity from (Name of State) _____

License/Certification is Current (Date) _____ Lapsed (Date) _____
Is this License/Certificate in good standing? Yes _____ No _____
Has applicant's license/certification ever been suspended or revoked? Yes _____ No _____
If yes, for what reason_____
Derogatory information, if any _____

_____
Date

Signature _____

Title _____

BOARD SEAL

State Board _____